Allergy Action Plan

Student's Name: _____ D.O.B.: _____Grade: _____

ALLERGY TO: _____

Age of first reaction: _____How many reactions has your child had: _____

How severe was your child's reaction: ____mild ____moderate ____severe

Has asthma? Yes* ☐ No ☐ *higher risk for severe reaction

▶ STEP 1: SIGNS AND TREATMENT ◀

Symptoms:		Give Checked Medication	
▪ If a food allergen has been ingested, but *no symptoms*		☐ Epinephrine	☐ Antihistamine
▪ Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat**	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung**	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart**	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. **Potentially life-threatening.

DOSAGE – medication must be supplied in original bottle/box with student's name on it

1st Antihistamine: give_____
medication/dose/route

2nd Epinephrine: inject intramuscularly (circle one) EpiPen® Dose_____ EpiPen® Jr. Dose_____
(if given – must call 911)

3rd Other: _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Student knows how to self administer EpiPen: ☐ yes ☐ no Student may carry and administer EpiPen: ☐ yes ☐ no

Doctor's Signature _____ Date _____
(Required)

▶ STEP 2: EMERGENCY CALLS ◀

1. Call 911 (State if an allergic reaction has been treated with epinephrine)
2. Parents: _____ Phone: _____Cell:_____
3. Emergency Contacts: (if unable to reach parent)
   Name/Relationship:_____ Phone: _____Cell:_____

I give permission to follow the above action plan and to share information with school staff and the healthcare provider about my child's medical condition so that they can work together to help my child manage his/her medical condition. This plan, when signed and dated allows my child's medicine to be administered at school as ordered by my child's licensed prescriber and on school field trips and remains current for this school year. I release the school personnel from liability in the event any reaction results from the medication. All medication will be sent home with the child at the end of the school year.

Parent/Guardian Signature _____Date _____
(required)

All authorizations expire at the end of the school year. Please notify school as needed for changes in health or medication.